Correspondence

History and Diagnosis

To THE EDITOR: I read with some personal delight the article in the February issue by Peterson and colleagues on contributions of the history, physical examination, and laboratory investigation in making medical diagnoses.[1] In my academic university practice (which I suspect is not unlike the departmental practice at the University of Utah Wasatch Clinics in Salt Lake City), many of my patients, referred by other physicians, come in carrying large bundles of papers. Over the years, the histories contained in these "referral packets" have become shorter and shorter and the number of laboratory diagnostic studies, roentgenogram reports, computed tomography reports, magnetic resonance imaging reports, endoscopy reports, biopsy results, and so on has become greater and greater.

Because both physician-referred and self-referred patients were included in the study, I wondered how many of the former brought with them laboratory reports as part of the "history." The word "history," if my experience is any gauge, has changed over the years to include less and less of the symptoms and story of the patient and more and more of the story of their previous medical investigative adventures. If this is so, then the implication of this study as to the importance of "history" does become different, as "history" may now mean "history of my diagnostic studies."

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REFERENCE

1. Peterson MC, Holbrook JH, Hales D, Smith NL, Staker LV: Contributions of the history, physical examination, and laboratory investigation in making medical diagnoses. West J Med 1992 Feb; 156:163-165

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To THE EDITOR: Peterson and co-workers have confirmed the primacy of the medical history in the evaluation of symptomatic patients who had laboratory investigation only when indicated.[1] Analysis of experience in our executive health program has afforded me an opportunity to assess the relative contributions of history, physical examination, and testing in mostly asymptomatic persons who, until recently, underwent a standardized testing protocol. Because this was a screening program, our review end point was not a final diagnosis but the identification of problems justifying further evaluation. That analysis showed most new discoveries were, indeed, made through the history and physical examination.

The results of 429 consecutive evaluations done over nine months were analyzed, with 40 notable new problems, including angina pectoris, leukoplakia, and prostatic nodules, found in 37 patients. Of these, 7 (18%) were found by history alone, 6 (15%) by physical examination alone, and 9 (22%) through a correlation of the history and physical examination. Of the identified problems, 14 (35%) were unexpected abnormal laboratory findings, but other studies such as radiologic procedures and pulmonary function testing had a low yield. These data underestimate the value of the history and physical examination in that certain problems such as excess weight, hypertension, and an unhealthy life-style were recorded separately and not included in this analysis. Elevated cholesterol levels were also separately reported and, had they been included in the laboratory analysis, would have increased the apparent yield of blood testing.

This analysis shows the importance of "low-tech" interventions in preventive care, just as Peterson and colleagues have shown the importance of the history in evaluating symptomatic patients.[1] Our preventive programs now emphasize history-taking and the physical examination, and standardized testing protocols have been replaced with targeted investigations.

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If Syncope, Think Long QT

To THE EDITOR: I want to congratulate my two colleagues in pediatric cardiology for their concise and informative overviews of heart disease in children in the April issue of the journal.[1,2]

I would like to add an additional comment. Unexpected and not readily explained syncope in children or adolescents probably deserves one piece of technology: an electrocardiogram. The long QT syndrome or Romano-Ward syndrome is a cause of sudden syncope and sometimes sudden death in an adolescent. There may be nothing in the history or physical examination to suggest heart disease, but if the results of a neurologic evaluation are negative, an electrocardiogram may elicit the definitive diagnosis. Immediate referral to an expert in pediatric electrophysiology would then be indicated.

No one is anxious to increase the cost of health care, but an electrocardiogram that uncovers a case of the long QT syndrome may well be lifesaving.

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1. Moss AJ: Clues in diagnosing congenital heart disease. West J Med 1992 Apr; 156:392-398
2. Hohn AR: Congenital heart disease—The first test (Editorial). West J Med 1992 Apr; 156:435-436

Correction

To THE EDITOR: I am writing you regarding my epitome, "Current Concerns with Collagen for Soft Tissue Augmentation," in the February 1992 issue.[1] The original publication stated that "To date, about 100 cases of dermatomyositis, polymyositis, and lupus associated with collagen injection disease have been reported." This statement should have read, "To date, about 100 cases of alleged associated autoimmune diseases have been reported in connection with collagen use." Although dermatomyositis, polymyositis, and lupus are clearly diseases within the family of autoimmune diseases, the associated cases of supposed autoimmune diseases reported with collagen use frequently do not have well-established diagnoses. This type of nonspecific presentation fits with the epidemiologic studies that have not been able to establish a causal relationship between these two factors.

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1. Piacquadio DJ: Current concerns with collagen for soft tissue augmentation, *In* Epitomes—Important advances in clinical medicine—Dermatology. West J Med 1992 Feb; 156:189